Energize Energize

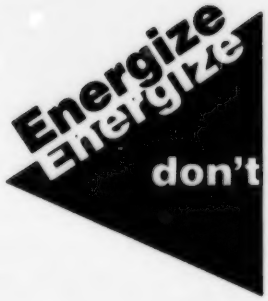
don't tranquilize

- Proceedings of Community Forums on Medication Substance Abuse and Seniors

Senior Advisory Council for Alberta

Alberta Association on Gerontology

AADAC Alberta Alcohol and Drug Abuse Commission



Proceedings of Community Forums on Medication, Substance Abuse and Seniors

Medicine Hat
March 7,1991

Grande Prairie
March 14, 1991

Calgary
March 21, 1991

Edmonton
March 25, 1991

Sponsored by:
Seniors Advisory Council for Alberta and Alberta Association on Gerontology

Assisted by:
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Special appreciation also goes to Dr. David Cook and Ms. Maureen Osis for their excellent presentations at the four forums.

Acknowledgement and appreciation is expressed to members of the Alberta Association on Gerontology in the four communities for their support in planning and for handling the local arrangements, and to the members of the community panels who brought in local interest and issues in their thoughtful presentations.

Finally, the sponsors would like to express appreciation to all those who attended and participated in the discussions. Their questions and comments enriched the days and helped to make the forums a success.

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1. INTRODUCTION

The Alberta Association on Gerontology (AAG) and the Seniors Advisory Council for Alberta (see Appendix A for a description of these bodies) were most pleased to co-sponsor four community forums on medication and drug use in seniors. The one-day forums were held in Medicine Hat on March 7, Grande Prairie on March 14, Calgary on March 21 and Edmonton on March 25. 1991.

The Association and the Council chose this topic because of the growing concern about this issue. It was felt that community education and discussion sessions would be helpful for both older and younger people and could assist in increasing understanding of the role that drugs play in the lives of today's seniors. It was also felt that, whenever feasible and appropriate, we should try to find alternatives to the use of drugs. Therefore, the title, "Energize, Don't Tranquilize," was chosen.

The planning committee, which was assisted by staff from the Alberta Alcohol and Drug Abuse Commission and the Alberta Pharmaceutical Association, chose two knowledgeable persons for the major presentations: Dr. David Cook, Chairman and Professor, Department of Pharmacology, the University of Alberta; and Ms. Maureen Osis, a clinical nurse specialist with the Southern Alberta Regional Geriatric Centre at Colonel Belcher Hospital in Calgary. Their presentations form the major part of these proceedings.

The Alberta Association on Gerontology, which handled all the local arrangements (as well as the registrations), found interested and knowledgeable local people to serve on the community panels, which concluded each forum. The purpose of these panels was to enable each community to review its resources and the activities it is undertaking related to this issue. The names of the panel members are in Appendix B, as well as the names of the local people who led the "energize" breaks at each of the forums. Local drama groups made a special contribution to each of the days, with their presentations following the luncheon. Appendix B contains the names of the groups.

The forums were co-chaired by the Seniors Advisory Council and the Alberta Association on Gerontology (AAG). Those who assisted with this were Micheline Neville, president of the AAG, Noreen Foster, member, AAG, and, from the Council, Marilyn Daines, Charlotte Germaniuk, Mary Norman, and Bette Purves.

The planning committee deliberately chose different types of locations for each of the forums. The Medicine Hat forum was held at Medicine Hat Community College, the Grande Prairie forum at the Royal Canadian Legion facility. In Calgary the location chosen was the Colonel Belcher Hospital and in Edmonton, a senior centre, the Society for the Retired and Semi-Retired.

Evaluations of the forums were completed by 193 of the individuals who attended. They were uniformly most positive.

It is hoped that the forums and the proceedings from the forums will stimulate further interest and discussion on this topic of growing concern to older people.

II. PRESENTATIONS BY DR. DAVID COOK, M.A., D. Phil.

Professor and Chairman, Department of Pharmacology
University of Alberta

Forums on Medication and Drug use in Senior Citizens

The three articles which follow this introduction represent the text of a series of talks to senior citizens and care givers on the problems of medications and substance abuse in senior citizens. While I have adhered fairly closely to the points which I made during my talks, I have taken the opportunity to add some relevant points brought out by questions, and to add a few comments which shortage of time prevented me from making during the presentations themselves. I am sure you will appreciate that when one is asked to give the same talk four times, no two presentations are identical, so I hope you will forgive me if the text which follows includes material which I did not discuss, or omits material that was mentioned. I hope the overall message - that we need to function as a team to provide the best health for seniors, that the patient and the patient's family are critical members of that team, and that intelligent and cautious use of medication makes sense from both a financial and a health care perspective - will have come through in both the talks themselves and the text which follows.

I would like to take this opportunity to thank Dr. J. Triscott, a geriatrician and member of the Department of Family Medicine at the University of Alberta, and Ms. Wilhelmina Martin, R.N., a former nursing supervisor at Norwood Extended Care Centre whose comments have been very helpful, and whose views have contributed significantly to my presentations. I am also very grateful to Maureen Osis, R.N., M.N., a Clinical Nurse Specialist in the area of geriatric health, who shared the presentations with me and whose exceptional knowledge, common sense and good humour taught me a great deal; to Mary Engelmann and Barbara Armstrong who provided flawless administrative help; to Micheline Neville from the Alberta Association on Gerontology for her assistance; and to the many members of the Seniors Advisory Council, the Alberta Association of Gerontology and the Alberta Alcoholism and Drug Abuse Commission, who made my participation in the programme so enjoyable.

Last, but by no means least, I would like to thank the seniors and the care-givers who attended the workshops, and whose questions, comments and anecdotes made me think in much greater depth about the vital but difficult issue of drug use and abuse in senior citizens.

David Cook, M.A., D.Phil.
Edmonton, Alberta, March, 1991

"Why we are where we are"

Introduction - Definitions

In order to discuss drugs intelligently, we need to have at least a few definitions established. Certainly one of the most important involves the names with which drugs are identified. Drugs each have (at least) three names. These are as follows:

Chemical name — This is an accurate chemical description, but is usually too cumbersome for routine use. An excellent illustration is provided by the common drug whose chemical name is 7-Chloro-1,3,-dihydro-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2(1H)-one!

Generic name — This is the "correct name" which is used by scientists, and which can be written on prescriptions. It provides an accurate definition of the drug, and has the same properties as the chemical name, but is usually much shorter. The drug mentioned above has the generic name of "diazepam".

Brand name — This name, sometimes referred to as the "trade name", is a registered name which is determined by the Pharmaceutical company which makes the drug. If the same drug is manufactured by a variety of different pharmaceutical companies, each will have their own brand name, although the drug may still be commonly known by the brand name of the first manufacturer. Diazepam is generally known as Valium®, but it could equally well be called Apo-diazepam®, Diazemuls®, Meval®, Novodipam® or Vivol®. These are still diazepam, but are manufactured by different firms, and the pills are of different shapes or colours, even for the same dose. The result is that if a prescription is renewed but the brand is changed, the pills will look different. Note that you can always tell whether the drug name is a trade name or a generic name because the character "®" appears after all trade names.

The rule in Alberta is that if the doctor writes a prescription for Valium®, the pharmacist may, at his/her discretion, change the brand provided that the generic name of the drug and the dose are the same. There are various techniques which the physician can use if he wishes to prescribe exactly the same brand. If he writes a prescription for "diazepam" any of the products may be used provided the dose is kept the same. Note that some forms of the drug are "generic" (in the above example, Apo-diazepam® and Novodipam® provide examples). This simply means the company which provides the drug is not in the business of developing drugs, but just of manufacturing drugs developed by other companies. These companies (Apotex and Novopharm) are sometimes called "Generic Drug Houses". These forms are often substantially cheaper to the consumer, although the issue of generic equivalence is too complicated to be dealt with here, and other issues than cost are involved.

TIP: If a prescription is supposed to be a refill but the pills look different, there are two possibilities: (1) a different brand of the same drug has been employed, or (2) through an error, a different drug has been substituted. The only way to be sure is to ask the pharmacist.

A second issue concerns the definition of the word "drug". A drug is any compound which changes the way our body or mind behaves, but there are some strange ideas about what are and are not drugs. Alcohol and tobacco ARE drugs. So are Aspirin®, Tylenol® and all the other over-the-counter medications. There is a widespread idea that herbs and products derived directly from natural sources are not drugs just because they are in some way "natural", and are thus possessed of natural healing properties with no concomitant dangers. This thought is not only wrong, but actively dangerous. Deadly nightshade, or the death cap toadstool are both natural and lethal, and both contain drugs! The dangers of unconventional therapy include any or all of the following:

1. Any new medical drug has to pass scientific tests which assess the safety and the effectiveness. Herbal and similar remedies have often either never been tested or the tests have suggested that the material is devoid of effectiveness. If the herb IS effective, the way to proceed is for scientific tests to be carried out to ensure that it really does work, and the scientists and doctors will then become supporters of that approach, not detractors. Some unconventional practitioners steadfastly refuse to submit their claims to any scientific scrutiny.

2. Use of unconventional therapies which are actually ineffective may delay the patient visiting a doctor and getting some effective help. In some cases the delay may permit the disease to develop to the point where NOTHING can help any longer.

3. Some unconventional therapies are safe, but many have significant health risks associated with them. We have seen illness and even death arising from this sort of approach. Very recently, two parents in Toronto were convicted of causing the death of their 1-year old child, by following the dietary recommendations of an unqualified practitioner. "Natural" does NOT mean safe!

4. The costs involved are often high, not covered by any form of medicare and the money goes simply to the individual marketing the remedy. The costs of conventional approaches to the user are often lower, and at least a proportion of the money gained is ploughed back into research.

TIP: Use good nutrition and "healthy" food but stay with established remedies prescribed or recommended by you doctor or pharmacist in the case of illness.

Over the last fifty years, our ability to manage disease has improved greatly, and by drug therapy, as well as by other advances in medicine, immunization, hygiene and so on, we are now able treat many diseases which previously would have been fatal or disabling. More people live into their seventh and eighth decades and beyond, and are often able to stay active and healthy. Despite these very positive developments, we have also reached a situation where there are significant problems, too. There is a huge and rapidly growing number of drugs on the market, and this can confuse not only the patient but also the health care professional. There are still a large number of unproven remedies available - I hesitate to use the phrase "quack remedies" because this implies a deliberate attempt to deceive, and many practitioners of "alternative" therapies believe in their approach. Nevertheless there is usually little or no reason to believe that these approaches work, and, for reasons outlined above, they can be harmful. Turning to the specific issue of seniors, this age group consume more drugs, both prescription and non-prescription, and have more adverse reactions to the drugs they consume, than do younger adults. The cost to society in terms of wasted

money on unnecessary drugs and to the health of senior citizens is considerable, and this has become increasingly obvious over the last few years.

The reasons for the negative aspects of present medical prescribing can give us a clue as to how to change the situation.

1. Increased and unrealistic expectations which have been raised by the dramatic success of drug therapy in other areas, can lead to great disappointment. The problem is not just that of the patient who expects that every ailment can successfully be managed by drugs, but also that of the health care professional who is sometimes reluctant to accept that he/she has done all that can be done to help the whole patient, and that additional therapy will merely add to the risk without providing significant additional benefits.

2. There is a great temptation to assume that because a drug has been given and the patient has improved, that the improvement was due to the biological action of the drug. Even an effective drug has its performance improved by the placebo effect. This the name given to the benefits (or sometimes the problems) obtained by the act of taking medication, which is unrelated to any real action of the drug on the body. Some conditions show a very high response to placebo medication, as do some patients. While this response is useful in that it does provide real measurable benefits, it can sometimes lead to the continuation of a drug which may never have been truly effective and whose entire action in that patient were related to its action as a placebo.

3. Health care professionals really are busy, and this can lead to carelessness or error. The problems seem to arise, at least in part, because the health care professional spends too much time in administrative matters rather than in patient care and contact.

4. Patients often have little information about drugs and diseases, and what information they do have may not be from a reliable source.

5. There is a great deal of confusion between three different sorts of ailments. Loneliness, rejection, boredom and similar conditions are diseases of society and do not respond to drug therapy. Poor nutrition, lack of exercise, drug

abuse and similar conditions are diseases of lifestyle, and also do not respond to drug therapy. Only true diseases of the body or mind such as arthritis, heart disease, or depression can respond to drugs, and even in these cases drug therapy may not always be indicated.

All these problems can be beaten, but only by knowledge and team work. The "Tip" below is important and sums up this presentation.

TIP: We will start to make progress when we see the health care team working together each with their own interlocking roles. There must be respect and real communication between the team members. The health care team MUST include the patient and the family of the patient.

"Drugs - harmful, helpful"

Benefit vs Risk

The most important concept in intelligent assessment of drug therapy is that of benefit versus risk. The idea is simple: each drug is associated with both benefits to the patient and risk of adverse effects. There are no drugs without adverse effects in at least some patients, and thus the prescribing physician must balance these factors. The patient needs to understand that there are associated risks, but in the opinion of the doctor these are outweighed by the benefits. Clearly if there are no benefits, all one has left are the risks, and this swings the balance toward the risk side, when effective therapy is designed to do just the reverse. Some drugs produce great potential benefits but also are associated with high risks of adverse reactions; others may be safer but are also less beneficial. The ideal drugs have the greatest benefit associated with the lowest risk.

TIP: Understand that no drug is completely safe - they can all produce harm in some patients, but they are useful where the benefits of the drug outweigh the dangers.

Changes in the body with aging

Although the changes which occur in aging can be slowed down by a sensible lifestyle, there are some changes which occur in almost everyone, sooner

or later, and they usually become clinically significant after the age of 65. Some of these changes are of relatively minor importance and will not be discussed in detail. The important ones are as follows:

1. The proportion of fat in the body increases, while the total body water declines. This means that if the same dose of drug is given, it will be dissolved in a smaller volume of body water and thus the patient will be exposed to a higher concentration of drug than was intended.

2. Liver function of the elderly may be reduced by decreased blood flow to the liver and also by a relative decrease in liver size. The former is more important than the latter. This means that the body will not clear a drug which is broken down by the liver as effectively, and thus, after repeated therapy, the plasma concentration of the drug will stabilize at higher levels than those encountered in younger adults given the same dose.

3. Kidney function of the elderly may be reduced by decreased blood flow and decreased tubular secretion. The effects are similar to those encountered in the liver, but are generally more important.

All these factors, as well as some that have not been mentioned, tend to mean that if the elderly are treated with the same doses of drugs which are used in younger adults, the concentration of the drug in plasma will be higher in the older patients, who may well show signs of overdose. Despite the fact that these cautions are well known, not all physicians make allowance for these changes, and this leads to medication of older adults with higher doses than are necessary, thus costing money and risking the health of the patient.

TIP: In the absence of any other information, older adults should receive about 2/3 of the normal adult dose. In the case of some drugs, this rule of thumb is not sufficient, and the dosage may need to be individualized.

Significant drugs

There are certain agents which pose particular problems in senior citizens, and some of these are discussed below.

1. Diuretics ("Water pills"). These agents are very widely used in older patients. The large number of adverse effects occurs because the drugs are so frequently prescribed more than because of their toxicity. On the other hand they do tend to produce electrolyte imbalances in older patients, such that loss of potassium or other similar problems which occur in all age groups, may be more severe. Some patients will be put onto additional medication such as "Slo-K" to replace lost potassium, although often this can also be achieved by suitable dietary measures. The drug furosemide (Lasix®) is widely used, but it produces a very profound loss of fluid, and sometimes this diuresis may be more than anticipated or desired.

TIP: Patients receiving diuretics should have their potassium monitored periodically, and an increase in potassium-rich foods such as bananas or apricots can sometimes be all that is needed to replace lost potassium. Note that not all diuretics cause potassium loss.

2. Anti-inflammatory drugs (Joint or Arthritis medication). The chief problem here is the well known adverse effect of gastric bleeding. The incidence of this varies and there are some substitutes for aspirin which produce less problems of this sort. Enteric-coated aspirin (Entrophen®) also produces less bleeding than normal aspirin, because the coating prevents the tablet disintegrating in the stomach. Acetaminophen (Tylenol®) is an effective pain-reliever, but has NO anti-inflammatory action. In some older patients the use of some anti-inflammatory drugs has resulted in anaemia from blood lost into the stomach and bowel.

TIP: Patients on anti-arthritic drugs should consult their doctor if they get severe stomach cramps or blackened foul-smelling stools.

3. Analgesics (Pain relievers). There are two classes of these. The first class which is used for management of mild to moderate pain, includes only acetaminophen (Tylenol®) and ASA (Aspirin®). Of these two, acetaminophen is safer as a pain reliever in older patients, but it cannot be used to treat inflammation and it must be kept out of reach of children; acetaminophen overdose is a serious problem particularly in children, and can be fatal.

TIP: In older adults acetaminophen is generally better for simple pain relief than ASA.

The second group includes the opiate drugs (formerly referred to as "Narcotics"). Of these codeine is the most popular for outpatient use. Some combinations with ASA (such as 222s® or Tylenol No. 1®) contain ASA or acetaminophen in combination with codeine at a dose of 8 mg, and these tablets can be obtained without prescription. Higher doses of codeine, alone or in combination, require a prescription. The major clinical problem observed with this group of drugs is constipation, and increased exercise and high-fibre products combined with an increased intake of fluids can often deal with this problem, without having to resort to more powerful laxatives. When the drugs are used in seriously ill patients, there is an additional problem in the elderly; depression of respiration is more common and more severe. This can be reversed with naloxone (Narcan®), but the protocol is complicated by the very short half-time for elimination of that drug. Nursing staff or physicians not familiar with the use of high doses of opiates should seek expert advice before instituting this approach to pain control. In the patient receiving such drugs as meperidine (Demerol®) or morphine, for severe pain, there is almost no risk of addiction developing because the "high" experienced by addicts is almost invariably absent in such patients. A particular problem is nervousness on the part of the physician or nursing staff about the possible adverse effects of the opiate drugs, which easily leads to UNDER-medication of the patient. There is absolutely no justification for a patient to be in severe pain because the dosage regimen is too rigid to allow them access to adequate analgesia.

TIP: If pain killers with codeine are being used, natural (bulk-forming) laxatives should be taken and if constipation persists a physician should be consulted. It is not a good idea to self-medicate frequently with things like 222s® except on the advice of a physician.

4. Sedatives (Sleeping pills). These are drugs which are used to induce sleep and the most popular agents which are currently used are referred to as "benzodiazepines". Representative drugs are triazolam (Halcion®), flurazepam (Dalmane®) and temazepam (Restoril®). These drugs do induce sleep and generally lack long-term side effects on the body, although they can have very serious effects on thought. In addition, if they are

discontinued, there is often "rebound insomnia" in which there will be a period where the patients will sleep badly - and thus be tempted to continue with the sedative. These drugs are sometimes useful for short term management of insomnia, but the temptation to use them for long periods of time should be resisted.

TIP: Sleep-inducing medication may be useful for short-term management of sleep disorders, but non-drug approaches should be tried first, and the medication should be discontinued as soon as possible.

Another issue which needs to be mentioned is the changing sleep patterns with age. For a variety of reasons older adults often do not sleep through the night, and may have difficulty falling asleep. One culprit is caffeine. The ability of this drug to produce insomnia varies widely from individual to individual, but with age our resistance to the effects of caffeine decreases.

TIP: If insomnia is a problem, try using decaffeinated beverages either all the time, or at least after 4:00 p.m.

As we get older we tend to have more frequent but shorter periods of sleep, and the insistence that elderly patients sleep through the night for the benefit of the staff is a form of abuse of the elderly. Every effort should be made to accommodate the changing sleep patters with age, and allow seniors to get up during the night to have a snack, a warm drink or a chat, if that is what they want to do.

TIP: If you are caring for elderly patients, respect the fact that they may not want to sleep all night, and work towards maximizing their personal freedom. If you are a senior, do not become concerned if your sleep patterns are different from those when you were younger. If you are wide awake at 3:00 a.m., read, get up and sit in a chair for a while, or do whatever you feel like doing - and if you're tired, go back to bed. The body will take what sleep it needs when it needs it, without the necessity for taking drugs.

5. Anxiolytic drugs (Tranquillizers or "nerve pills"). These drugs, which are also classed as "benzodiazepines", include diazepam (Valium®),

chlordiazepoxide (Librium®), Oxazepam (Serax®) and Lorazepam (Ativan®). They are designed to deal with excessive anxiety and worry. The drugs actually seem to blunt our ability to appreciate the highs and lows of life, and it is not surprising that they can also produce sleep or a stuporous state, if we give larger doses. These drugs can be treated the way we treat sleeping pills. They are OK for short term use, but only if non-drug approaches have been tried first, and they should not be continued for long periods of time in most patients. There is a clear-cut physical withdrawal syndrome if the drugs have been used at higher doses, and withdrawal even from lower doses is often very difficult for the patient, and may require psychological support for several months. The issue of the long term use of these drugs is complicated, but at best they blunt our experience of the highs as well as the lows, and I personally believe that we do best when we can really experience life, rather than spending it as a partial zombie! It is also worth pointing out that some older patients become excited, confused or disoriented when given these drugs.

TIP: Short-term use of these drugs is sometimes useful, but you should discontinue them as soon as possible. Be particularly on your guard against increasing the dose of the drug yourself, and encourage the doctor to limit refills and to use the agents for short periods only.

6. Drugs for major mental illness - anti-depressants, drugs for manic-depressive disease, drugs for schizophrenia. These are the "big guns" of the psychiatrist's armament and are used in patients with severe problems, although there are some less serious conditions in which low doses of the anti-depressants have proved to be useful. The problem here is that some individuals feel that their mental health is coming out of a bottle, and stop taking the drugs. This is like an insulin-dependent diabetic stopping his insulin! By all means discuss with the psychiatrist whether it is worth while trying to stop taking the medication, but do not act unilaterally - these drugs may be needed for life.

TIP: If you are on medication for depression or manic depressive disease or schizophrenia, do not stop taking your medication because you feel that you have been cured. Make no changes without discussing the matter with your doctor first.

Note that the benzodiazepines are not effective for depression - they may make it worse. Note also that a disturbingly frequent use of the anti-psychotic drugs such as haloperidol (Haldol®) is as a chemical restraint in patients who may not need it. There has been more than one instance of a patient who has refused sleeping medication, or taken it and developed a paradoxical excitement, being diagnosed as suffering from senile dementia and "calmed" with large doses of Haldol®. If drugs like this are to be used, there MUST be a clear diagnosis, because the agents do have severe adverse effects. It is easy for a patient to be transferred to a nursing home, be medicated to "help them with the move", and to end up on benzodiazepines, haloperidol and other drugs to the point where a couple of months later they are confused, wandering and showing signs of Parkinson's disease as a result of medication with haloperidol. This is often wrongly attributed to the onset of senile dementia rather than to adverse effects of prescribed medication. Note that the situation is quite different from the rational use of such drugs in the management of true ongoing mental illness.

TIP: Rule out any possible adverse effects of medication before deciding that a patient is suffering from senile dementia.

7. Anti-hypertensives, anti-dysrhythmics, drugs for congestive failure, drugs for angina (Blood-pressure or heart pills). These are effective and important medications, and failure to take them as directed can have serious of even fatal consequences. Make sure that you understand what the medication is for, and how it is to be taken.

TIP: Make sure that heart and blood pressure pills are being taken EXACTLY as instructed. If the instructions are confusing, get them made clear.

(For patients) - How to treat your doctor

Most doctors are hard-working, caring individuals. The patient can help the doctor make the right decisions by playing their part in the management process. Note that this is not trying to take over the doctor's job, but playing your role as a patient. You should try to work together like a singer and a back-up pianist work together - the roles are different but each one has to try to help the other to

sound as good as possible. It is not sensible to say "Well, I'm the consumer and the doctor is working for me, so I should have the right to ignore everything he/she says". It is equally unwise to say, "The doctor knows everything, and so I must do everything he/she tells me without any question". You have responsibilities for your own health, just as the doctor has the responsibility of giving you good advice and information. Here a few ways you can help the doctor to do a good job.

1. Make sure that you understand exactly what is wrong with you. If the doctor merely writes a prescription, ask him what is his/her diagnosis.

2. Ask about adverse effects you may expect, and what to do if they occur. Your pharmacist can help here, as well.

3. If you are concerned about the number of different medications you are using, set up an appointment with your doctor for a medication review. At that time, bring in ALL your medications INCLUDING ANY NON-PRESCRIPTION DRUGS WHICH YOU TAKE REGULARLY.

4. If you are not clear, about any information or instructions, ask the doctor to write the information down.

5. Do not wait for your doctor to tell you to diet, exercise, quit smoking etc. Take responsibility for a healthy lifestyle yourself, but do make sure that your doctor knows what is happening. In particular, if you are planning on a diet or exercise programme, tell your doctor first.

6. NEVER pressure your doctor to prescribe any medication, and particularly do not pressure him or her to prescribe a specific drug. If the doctor does not think you need a drug, be grateful that you have been saved some money by not getting a prescription for something useless.

7. Do not lie about your use of alcohol or tobacco. It is like lying to a member of your sports team or your drama group about your abilities. You are all on the same team - tell the truth.

8. Demand real communication - if you do not understand, say so. If the doctor uses words you do not know, ask him/her to make it clear to you.

9. Do not waste the doctor's time. We have friends with whom to discuss our family problems and triumphs and just to chat - the physician is there to look after our health. All too often, we tell the doctor all the details of our social life - and then ask medical advice from our next-door neighbour! An excellent way to ensure that you get the most out of your visit to the doctor, is to MAKE A LIST before you go, of all the things you want to know or want to tell the doctor. If you respect the fact that the doctor is busy, you will get a much better relationship with him or her.

10. Use ONE doctor and ONE pharmacy. The family doctor may refer you to various specialists, and that is fine - there is usually a good flow of information between the specialist and the family doctor. **Never** visit several family doctors and get prescriptions from each.

11. Do not give other people medication intended for you, and do not take medication intended for others, even if the condition is apparently the same and the pills look the same.

12. Do not demand referral to a specialist. This is a decision your physician can make. Family doctors have plenty of necessary skills for dealing with common conditions. Family medicine is not a refuge for those who could not get into a specialty, but is a specialty in its own right - and not a particularly easy one!

(For care givers) How to treat your patient

In the same way that the patient has to play their part, so of course, do the other members of the team - the doctor, nurses, nursing aids, pharmacist and so on. Here are a few ways in which you can help the patients behave in a fashion which is going to maximise their health.

1. Encourage the patients to stay in control of their lives and medications. In certain instances, the patient may have dementia or some other disabling condition, but as a general rule you should not try to make decisions for the patient which the patient should and could make for themselves. Do not patronise the elderly - they often have at least the mental acuity of younger adults, and they deserve to be treated as adults, not as overgrown children.

2. Make sure the patients have access to factual information. Be prepared to recommend books on health, and have available accurate brochures on their condition which will help them to understand what is wrong and what can be done to fix it. These leaflets are often available in pharmacies and are very useful. If this is not available, some patients will start to rely on the views of untrained individuals or on less reputable written sources of information.

3. Try to see things from the perspective of the patient. Many patients do not appreciate that non-prescription medication is potentially harmful, and may well not include it in a medication review - you must ask about it. Equally, if you make the patient feel embarrassed about some damaging aspect of their lifestyle, they are more likely to lie about it in future than to amend their ways. Care-givers must be able to communicate honestly with the patient and this means that an attitude of omniscience or superiority is not helpful.

4. **NEVER** use "take as directed" as a prescription instruction unless you have provided full WRITTEN instructions that the patient can take away with him/her. **NO EXCEPTIONS!** Patients do not remember verbal instructions, and they will either get it wrong, or will ask the pharmacist who will either have to make up the instructions, or call the doctor. All instructions should be written not verbal, should be easily intelligible, and should avoid the use of obscure acronyms. The purpose of instructions or orders is that they should be followed, and neither the patient nor the other members of the health care team will appreciate having to guess. The problem of poorly written material, or information which is not written down, is not just a problem of the physician; other members of the health care team can make the same mistake.

5. Do not try to do everything yourself. A home care nurse may have no experience in dealing with the addiction problems of one of her patients. A physician may not have much knowledge about counselling someone whose spouse has just died. A nurse in an extended care centre may know nothing about "living wills" and be unable to provide advice. There are good social agencies and individuals who HAVE the knowledge and can help. The home care nurse should call AADAC and not try to handle the situation without advice, the physician should try to put the patient in touch with a

counsellor or minister or someone who can help, and the extended care centre nurse should suggest that the patient seek advice from a patient advocacy group. That way the care giver will have more time to deal with the problems they do know how to solve, and the patient is more likely to get a sensible answer or approach.

General behaviour (Approaches for everyone on the team)

There are a variety of things that can help everyone.

1. Accept the limitations of therapy. Realise that there may be NO known drug which will help. The physician should not feel that he/she has not done his/her job because of an inability to come up with a drug to help. What you may have done is to prevent the patient experiencing unpleasant (and even fatal) adverse effects from a drug that the patient did not need in the first place. And the patient needs to understand this principle as well.

2. Involve the pharmacist. The pharmacist is a highly trained professional and in the best situation is a vital and respected part of the team. Physicians can gain advice about drugs, as can patients, and it is a waste of a valuable resource if we do not use it.

3. Limit the use and recommendation of non-prescription medication -there are lots of possible problems with people who over-medicate with over-the-counter products. Encourage the patients to use less rather than more.

4. Support medical research. Here are a couple of statistics: at present more than two-thirds of the projects which could help us to combat disease fail to get supported, usually not because the projects are no good, but because there is no money from the Canadian Government. Recently the Government started a widely-publicised "Centres of Excellence" programme which received 158 applications for collaborative projects by major Canadian scientists - they funded 14 of them! The Federal Government clearly do not believe that people care about this issue - keep pressure on them to provide adequate support for health research. If the Alberta Government had not taken the initiative of starting the Alberta Heritage Foundation for Medical Research - and even that is currently short of funds

- medical research in this Province would be in an even more serious position.

5. The reward system for Alberta physicians is usually on a fee-for-service basis, and and this often makes good sense. Unfortunately the way the system is structured, means that there is no financial reward for spending more time with the patient. In fact someone who is interested in the health of the senior citizens, and is thus forced to spend more time dealing with patients who generally have a larger number of diseases, winds up losing money vis-a-vis someone who spends much less time with each patient, but can see a larger number of them. This arrangement needs to be changed, and everyone should work together to try to get it changed. Payment by the hour may not be the answer either, by the way. The issue is not a simple one, but attempts need to be made to modify the present system.

6. Savings resulting from more careful use of medications are not, I believe, usually passed on to the unit which has saved the money. Thus if an organization decides that, without increasing the overall budget, it can reduce the number of sedative prescriptions and use the money saved to hire an additional night-shift nurse to deal with any patients who wish to be up and about in the small hours of the morning, it may not be possible to gain approval for that approach. If we wish to reduce unnecessary prescriptions, other non-drug therapies and approaches may be necessary, and at least the savings on reduced medication should go to support such services if they are required.

TIP: Everyone should be aware not only of the individual health problems, but the larger issues surrounding health care, so that they can provide useful input to their elected representatives.

"Hitting the highs to cope with the lows"

This section deals with the issue of the abuse of alcohol and tranquillizers in senior citizens. There is only a limited amount of information in this area, and those who would like a more comprehensive survey are referred to the annotated bibliography prepared for the Alberta Association on Gerontology and the Alberta Alcohol and Drug Abuse Commission by the Southern Alberta Regional Geriatric Centre at the Colonel Belcher Hospital in Calgary.

Introduction and Definitions

One of the major problems in discussing substance abuse is that very often there is no common language. The word "addiction" can take on a variety of different meanings, and many words have strong overtones associated with their use. Consider for example, that what one person might call "drug abuse", another might call "non-medical drug use" and a third might call "use of recreational chemicals"! The three major definitions are as follows:

1. **Psychological dependence**. This is a craving or perceived need for a drug, and it can be present to a greater or lesser extent. The mildest form of psychological dependence is referred to as "habituation" and it describes the circumstances where an individual is used to consuming the drug, likes the drug and would prefer to have it available, but if the drug is not around they will not go to extraordinary lengths to obtain it. An excellent example is provided by the psychological dependence most North Americans have on caffeine. The majority are **habituated** to caffeine, but are scarcely full-blown addicts. On the other hand, someone who is **addicted** to narcotics or cocaine places the consumption of the drug above almost everything else, and if they do not have access to the drug, they will go to extreme lengths, sometimes including murder, to obtain it. The two most medically important substances which are abused are alcohol and tobacco, and those who are psychologically dependent on these substances, often fall quite far along the scale of addiction, despite frequent protestations that they are not really addicted, just habituated!

2. **Withdrawal syndrome.** This used to be called "Physical dependence" but the phrase has fallen out of fashion because it is easy to confuse it with psychological dependence. Briefly, after taking a drug for some time, the body may adapt to it such that it actually functions better when the user takes the drug than when he does not. Under these circumstances, when the drug is withdrawn, the patient will go into a withdrawal syndrome in which they may become physically ill enough to require medical attention. Abrupt withdrawal from some drugs has, on occasion, been fatal. Some drugs which are used for non-medical purposes produce a withdrawal syndrome when the drug is stopped (for example alcohol and high doses of sedative drugs) while others produce a syndrome which is mild or non-existent, and does not require medical attention (for example tobacco and marijuana).

Whether a drug produces a withdrawal syndrome has almost nothing to do with addiction or more mild forms of psychological dependence. Indeed some agents such as the corticosteroids are not thought of as "addicting" at all, nevertheless, sudden withdrawal from these drugs is medically very dangerous.

3. **Tolerance.** Tolerance is the process by which the user has to take more and more of a particular drug to obtain the same experience. Like physical dependence, it has little to do with addiction and is a property of some drugs but not others.

One important point is that we need to be clear that the problems in drug addiction reside with the **user** not with the drug. Many people can use alcohol on a casual basis and are certainly not addicted, and probably not even habituated to it. On the other hand, other individuals develop a severe dependence on alcohol, and if they do succeed in ceasing to use it, usually they cannot consume even small quantities without the craving for the drug being re-established. It is probably true that compulsive use of drugs is an illness, but the user should not be allowed to put the blame on the drug, but rather on the interaction between the drug and the user.

Alcohol

Alcohol is not always considered by the user to be a drug, despite the fact that it clearly should be classified as such. We are occasionally faced with the sight of an alcohol user becoming amazingly self-righteous about the use of other drugs, an event which would be amusing if it were not pathetic. There is an overall incidence of alcoholism in society of about 5-10%, of which only a small proportion fit into the category of "skid row" alcoholics. The incidence of alcohol abuse in seniors is slightly lower, and alcoholism in males is significantly more common in the older population. The alcoholic has a lifespan which is shortened by about seven years vis-a-vis the abstainer or social drinker, and in addition to the reduced lifespan, the QUALITY of life is severely diminished. Alcohol abuse is associated with significant health problems, not just in the liver (which usually shows "alcoholic fatty liver" before cirrhosis) but in the stomach, the heart (alcoholic cardiomyopathy) and muscle. There is good evidence of impaired mental function which seems to arise from damage to the brain itself. In addition

to these problems, alcoholics often have other nutritional deficiencies, particularly of vitamins, and a much greater risk of accident from falls, car accidents, fights and so on. In some inner city hospitals it has been estimated that almost one-third of hospital admissions are alcohol-related.

In addition to the health problems, alcoholics almost invariably encounter major difficulties in other aspects of their lives. Few employers are prepared to tolerate the frequent absences, lateness and poor work performance which characterise the alcoholic. Impairment of performance at work may not be immediately obvious, but it will almost always surface eventually. Home life and relationships with spouse, children, relatives and friends are usually seriously impaired. Alcoholics tend to seek support and friendship with other alcoholics, because few people wish to spend much time with an individual who is drunk most of the time. The final group affected by the alcoholic are the care-givers - doctors, nurses, and particularly those in the home care programme. The frustration of dealing with someone who is ruining their own life and placing an enormous and unnecessary burden on the health care system, can be considerable, and this aspect is discussed in more detail later.

Tranquillizers

The word "tranquillizer" is a little old-fashioned, in the sense that we now recognise that this term embraces a large number of drugs with different mechanisms of action and different clinical uses. In general this refers to drugs which induce sleep, calm anxiety and generally reduce activity, physical and mental. As was pointed out in the previous text, use of the these drugs in the short term is sometimes helpful, but because they have the effect of insulating the user from emotional highs and lows, it becomes very easy to continue to use them long after the need has evaporated. The drugs are in some ways similar to alcohol, and an alcoholic who no longer drinks, can readily become dependent on drugs of this class.

Dependence usually starts when the drug is prescribed to deal with a particular crisis. It is clear that when these drugs were first introduced, they were greatly over-prescribed. There is now a much greater awareness of the problem, and prescriptions are now less frequent, although these drugs are still used very widely. Weaning someone off the drugs when they have been taking them for some time can be very difficult, particularly if the patient has been taking larger-

than-intended doses. While the effects on health are less important than with alcohol, patients who abuse tranquillizers will have similar problems in terms of work, social life and interactions with care-givers. If the patient is withdrawn from the drug, it often needs to be done slowly, under medical supervision, and with consistent and experienced psychological support.

Behaviour of addicts

The most useful definition of a substance abuser is someone who encounters obvious problems of health and/or social function as a result of the use of the substance, and still CONTINUES TO USE IT. There are various indicators of substance abuse, including secretive use of the agent, and denial of excessive use. Thus, an alcoholic will keep liquor in places in the home where it can be accessed secretly, empty bottles may be disposed of in other people's garbage. and so on. Alcoholics and tranquillizer abusers will usually not deny that they use the drug, but report their use at a much lower level than that which actually occurs. It is very common for the addict to deny in public that there is any problem, although he or she may spend a considerable part of their time alone worrying about their drug use. There are often attempts to quit or to reduce consumption of the drug, in order to prove that the person is in control. These are sometimes successful in the short term, but unless help is provided, the users will almost invariably revert to their former pattern of drug use, despite the fact that it is obvious to anyone that the problems are drug related and are becoming ever more severe. In some instances the addiction will stabilise at a socially acceptable level, but usually the condition will worsen with the individual ultimately reaching the state where they are unable care for themselves, and with few people who are interested in helping.

Behaviour to addicts

Most care givers and relatives and friends are understandably deficient in knowledge about dealing effectively with addiction in someone close to them. The substance abuser is not usually likeable, it is often hard to respect them and the situation is very difficult, particularly for those who really care for the addict. Instinct is not much help here - it is easy to adopt behaviours which are intended to help but which may actually make the problem worse. The whole issue of the

management of addiction is too complicated to be discussed in detail, but there are a few tips which may help, if this is a problem in the home or the workplace.

1. Get a professional involved. There is no shame in admitting that you are having problems with a drug yourself, nor in admitting that you care for someone with a problem. If you encounter the substance abuser as a patient you are trying to manage, few nurses, doctors or other professionals know what to do. The Alberta Alcoholism and Drug Abuse Commission (AADAC) is in the phone book and has a team of friendly, compassionate and well trained staff who can help. They provide assistance not only to the addict but to family members or others who have been affected by the problem.

2. It is very easy to moralize about this issue, but it is worth bearing in mind that alcoholics or substance abusers are really not very different from the rest of us, but have the misfortune of being unable to deal with the effects of drugs on their behaviour. Addicts can be helped, but not usually by anyone with an attitude of moral superiority. Dealing with an addiction is NOT merely a question of will power as some seem to believe. "Just say 'no' to drugs" is a good policy for those who are not already users, but to suppose that this is all it takes to break an addiction is as naive as telling someone who is suicidally depressed, "Just cheer up!".

3. While you should avoid moral outrage in dealing with addicts, it is not helpful if you actively support the addiction. This behaviour is sometimes called "enabling" and includes such things as helping to establish alibis for those who have failed to show up at work because of drinking, covering for behaviour of the addict - "John isn't usually like this - it's just that work has been so difficult for him recently", "It's not her fault that she's an alcoholic - with a husband like that, can you blame her!" etc. etc. This provides the addict with a way of escaping from the consequences of his/her addiction and sometimes of putting the blame on someone else. The fact remains that however good or bad life is, an addiction will make it worse. The addict must take responsibilities for his or her actions, just like any other adult, and, if we allow addicts to escape from those responsibilities, we are ultimately doing them no favours.

4. The reason substance abuse is a problem is not because of the drugs but because of the consequences of their use. This may seem like splitting hairs, but in dealing with the substance abuser, documenting the extent of drug use is seldom helpful. It tends to produce argument and secretiveness, and in addition it gives the addict a chance to evade the real issue. Often one hears, "you're not going to have ANOTHER drink, are you? That's six this evening". "That's a lie - I've actually only had three drinks all night." There is then a big argument about whether the figure was six or three, and the alcoholic makes a mental note to pour himself fewer but much larger drinks in future! The real issue is the problems which result from the substance abuse. Not: "I thought you promised your doctor that you wouldn't take those tranquillizers that you got from the other clinic" but, "I find it difficult to try to talk to you when you are sleepy all the time. It does not make for an interesting evening for me". Not: "I don't want you drinking on the weekends" but, "if you are late for work without a doctor's certificate NEXT Monday, I will have to review your position with the company. You have been late every Monday for the last five weeks". Document the behaviour and not the extent of drug use. You and the addict both know what the problem is, but if you document behaviour you can sidestep a whole series of futile and time-wasting arguments.

5. It is important to look after yourself. If you are a home care-nurse, and a visit which should take half an hour takes two hours because the patient is an alcoholic and is stuporous or uncooperative, you will end up putting in another (unpaid) hour and a half each visit. This will ultimately cost you or the taxpayer or both a certain amount of money, and may make you angry and frustrated enough to have an impact on other aspects of your life. The closer you become to the addict the greater will be his or her influence over you, and we know that spouses and children of alcoholics often have severe psychological problems as a result of being involved in the addiction. If you really want to help, it will be very difficult if you are becoming mentally unhealthy yourself, and all too often the friend or care-giver of a substance abuser find themselves in the same position as someone who jumps into the sea to help someone who is drowning, only to drown as well. To avoid this problem, get good professional help, do not let the addict put the blame on you for what is truly THEIR problem, and make sure that you have a circle of happy, healthy, non-addicted friends and relatives. Do not let the addict drag you into their world, and if you feel that this is

happening, get help for yourself at once. Being involved with an addict at any level is not a lot of fun - they have a rare ability to make others feel angry and guilty at the same time - so be careful!

III. PRESENTATION BY MAUREEN OSIS, R.N., M.N

Clinical Nurse Specialist, Colonel Belcher Hospital

DRUGS: THE DELICATE BALANCE

Our previous presenter, Dr. David Cook, discussed the risk/benefits of drugs, how we got where we are with drug use, and the disadvantages of relying on drugs to cope with daily living.

My presentation will focus on tips for safer drug use and alternative approaches in the hope that you will be better able to achieve the "delicate balance."

MYTHS OF AGING

First, a few brief words on aging. In our society "Everyone wants to live as long as possible, but no one wants to grow old" (Lancaster). Mark Novak has written an excellent book called Successful Aging which dispels some of the common myths related to aging.

Myth #1: All old people are senile. Absolutely NOT true. Individuals who develop dementia have a disease - not aging.

Myth #2: Old people are sick. Again NOT true: the majority of older persons do experience various kinds of health problems but manage their daily lives in spite of these difficulties. In fact, only a small percentage of older people need chronic (or extended) care.

Myth #3: All old people are alike. The only time in our lives that we might be alike is at birth; and even then, we are very different. This myth must be dispelled when we are planning programs or educating the older population.

Myth #4: Middle age children are abandoning their aging parents. This is simply not borne out by the statistics, nor by my experience working with families. Novak found that the majority of older individuals had spoken to or visited their adult children daily or weekly.

THE BENEFITS AND RISKS OF MEDICATIONS

A. What can medicines do?

Medicines are chemicals that alter the body or mind or affect micro-organisms. All drugs have benefits and risks: that is, they can reduce pain, cure disease, or alleviate symptoms but they can also cause side effects (or adverse reactions).

B. What are the common types of medicines?

The word medicine refers to all those drugs ordered by a physician as well as OTCs or over-the-counter products bought for self-medication. This includes alcohol and caffeine. Some so-called "health food products" are also used as drugs: that is, they are taken to alter the mind or the body. These products are not risk-free as is commonly believed. Next time someone says "Well it can't hurt me, after all it's natural," just remember that botulism is natural too!

A safe principle in deciding to use or not use any medication is "A medicine is useful if the expected benefits outweigh the risks involved in its use" (World Health Organization).

C. Adverse Drug Reactions

These refer to the unintended consequences of drug therapy. It is estimated that 10-15% of the elderly population will have an adverse reaction to drug therapy. Adverse drug reactions are 2-7 times higher in the over 60 year age group. For example, in hospital the incidence of these effects is estimated at 3-8% in those under age 60 but increases to 11-21% for those over age 60. Approximately 16% of admissions to psychogeriatric units are due to adverse drug effects. Drug induced illness accounts for 5-30% of hospital admissions for those over age 65.

Older adults have the potential to experience the greatest benefit from drug therapy; unfortunately, they also experience the greatest and most serious side effects.

SAFER DRUG THERAPY

A. What can you do to remember to take your medicine?

Using a calendar to check off each dose or putting pills into a Dosette can be very helpful in remembering each dose.

B. What should you do if you miss a dose of your medicine?

Generally speaking, you can follow this rule: when you notice that you have missed a dose, look at the time and calculate which is closer--the time of the dose that you missed or the next dose that you will take. For example, you usually take your blood pressure pills at eight A.M. and six P.M. and it is noon. It is four hours since the missed time and six hours until the next time: take the dose. However, if you did not notice until two P.M. (six hours since the missed dose and only four hours until the next dose) skip the dose and carry on with your usual routine. Do not double any doses. If uncertain, contact your pharmacist for advice.

C. Where should you store your medicines?

First, and foremost, your should keep all your medicines out of the reach of children and in their original container. If you need to take a supply of pills with you for travel, be certain to label them.

D. When you stop taking a medicine, what should you do with the remaining supply?

Ideally, to prevent contaminating our water supply, you should take your pills to your pharmacy for disposal. Never use expired medications. I challenge you to check your home TODAY - I'll bet you will find at least one expired medication or vitamin.

E. What should you do if you think you are having side effects to your medicines?

Call your pharmacist and check whether your problem could be related to your medications. Make a note of the problem and when it occurs. Discuss

with your physician. The book by Griffiths (see the end of this article) is very helpful in sorting out side effects and what actions to take. Do not take another pill to cure the side effect; we need to change the thinking of "One pill for every ill" to "One ill for every pill!"

Peter Lamy, a well-known author on drug therapy, comments that the person taking four medications is "playing Russian roulette with four of the chambers loaded." Expect side effects if you combine prescription and OTC drugs or medications with alcohol.

F. Where should you get your medications?

Purchasing all your medications at the same pharmacy has several advantages. You get to know the pharmacist and will feel more comfortable asking questions; but more importantly, the pharmacist also gets to know you and the complete profile of your medications. Pharmacists are valuable community resources to advise us how and when to take drugs, and warn of side effects or dangerous combinations; e.g., what might happen if you take a certain drug with alcohol. Select your pharmacist as carefully as you select your physician. Don't bother saving a few cents by driving around town for "bargains;" your health should not be risked for minor savings.

G. What should you ask the doctor or pharmacist?

Each time you take a prescription drug or product for self-medication you should know:

- name of the drug?
- what effects should I expect?
- when do I take the drug?
- when do I return for follow-up?
- what are the indications for stopping the drug or calling the doctor or pharmacist?

H. How can you make drugs safer?

1. Select a doctor who orders drugs carefully.
2. Go to the same doctor.

3. Use the same pharmacy.
4. Ask questions before you get prescription or OTC drugs.
5. Do not combine drugs or alcohol without advice.
6. Report side effects.
7. Follow instructions carefully.

- Occasionally, take all your medications to your physician and ask for a review; should I still be taking these pills?

I. What can you read?

Griffith, H. (1988). Complete guide to prescription and non-prescription drugs. Los Angeles: The Body Press.

ALTERNATIVES TO DRUGS

I work with a group of seniors ages 70-96 years, and I run a health promotion program for these people. I have observed many successes with alternative approaches to the problems of daily living, the most common being pain, anxiety, insomnia and constipation.

For pain, the application of heat or cold is very effective. One woman with severe arthritis in her knees uses a package of frozen peas: apply for 20 minutes and then refreeze (It's reusable and doesn't constipate like many pain killers!)

Another effective method is massage. Recently, we had a demonstration of self-massage techniques for the feet, hand, neck, scalp and face. We have also experienced the fun and benefits of giving each other a foot massage.

Walking is a wonderful activity; it is relaxing, renewing, and requires no equipment except good, safe shoes. Last year we had a "Walk Across Canada" program, and I was amazed to witness the improvement in several individuals in terms of their energy levels, gait and posture, and emotional well-being. One gentleman, a 77 year old man recovering from a stroke, logged several kilometres per day much to everyone's surprise, including his own. This program also had a social component: as we "reached" each province, someone who had lived there gave a short presentation to us while we enjoyed a cup of tea.

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Aquacise is a very effective method of improving flexibility, muscle strength and endurance. One woman, who is entering her late 70s, was almost incapacitated with back and leg pain which did not respond to traditional therapies. One year later, with regular aquacise, she is much more mobile, able to enjoy short shopping trips, playing bridge, and visits to her children and grandchildren.

Visualization is easy to learn and very effective for pain management as well as reduction of anxiety. Two other useful tools are progressive muscle relaxation and "creative worrying." For the first, you can visit your local library for books and tapes on relaxation or ask a local seniors' or community club if classes are available. The second tool refers to strategies that help us tune out or turn off when we feel anxious; everyone has worries but worrying is like a rocking chair--it keeps you busy but doesn't get you anywhere. In my classes on stress management, we discuss ways to make worrying more effective and less stressful.

Insomnia is a commonly-heard complaint by anyone working with older persons. When a senior says to me "I don't sleep well," I usually reply "of course you don't." It is unfortunate irony that at a time of life when we could have uninterrupted sleep--we can't. Fractured sleep (awakenings during the night) is the norm for the older person. Perhaps it is even healthy. Joints and muscles become very stiff while sleeping. The nightly trip to the bathroom could be considered an exercise break! Regarding the use of sleeping pills for this problem, I have many concerns. I have seen people fall after using these pills and falling is far more detrimental to your health than insomnia. I am also concerned that we use pills to control a phenomenon, namely sleep, that we have only recently begun to understand. Studies have shown that the average amount of sleep you gain by using sleeping pills is only 20 minutes! It is not worth the risk. One program called "Getting a Good Night's Sleep" has been very popular with seniors in the Calgary community. I have learned of very many approaches for successful sleep from these people but the most impressive, I think, came from a pair of friends who had been widowed and were experiencing the loneliness and adjustment of living alone. They discovered that a phone call each night had several benefits; they could check on each other, find out what happened that day, and experience warm human contact just before retiring. A creative solution without SIDE EFFECTS.

Finally, I will make a brief comment on constipation, a very unpleasant symptom that accompanies inactivity and the use of pain killers that contain codeine. Your

first strategy should be dietary changes: increase fibre, especially fruit, and increase water intake. (How many of you drink six glasses of water each day?)

A pharmacy student doing a study of drug use noted that laxatives and sleeping pills were among the most frequently used and concluded that we must be "a society of constipated insomniacs." It is possible to change this through the alternative measures I have just described.

REMEMBER: THE ONLY DRUG THAT DOESN'T CAUSE A SIDE EFFECT IS THE ONE YOU HAVEN'T TAKEN.

EXPLORE ALTERNATIVES TO DRUGS--NOT ALTERNATIVE DRUGS!

ENERGIZE, DON'T TRANQUILIZE.

DRUGS AND THE OLDER PERSON: HOW MUCH IS ENOUGH? LESS IS MORE.

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION "WELL-INFORMED," A PREVENTION PACKAGE FOR SENIORS

Well Informed is AADAC's prevention package for seniors. It is part of the Lifelines series of comprehensive treatment and prevention resources for use by individuals, organizations and communities.

This package is designed to encourage strategies and environments which support seniors in maintaining or improving their health. It contains material for use by those who work with or provide care for seniors, and for use by seniors themselves.

Components

Workshop manual: "Learning to Help" workshop guide contains session plans, overhead masters and worksheets for 4 one-hour workshop sessions for people who work with seniors. Manual also includes background information sections on "Medications and Older People" and "Alcohol and Aging."

Videotape: Used in conjunction with workshop sessions; can also be used independently to promote group discussion.

Booklets for seniors: Three self-help booklets designed to encourage seniors to assess their overall health and their use of medications and alcohol, to determine if there are things they could do to maintain or improve their health. Also integrated into workshop material. Titles are: "Growing older - Staying healthy," "Making medicines work for you," "Alcohol - Some things to consider.

Targets

Community workers, e.g.:

- staff in seniors' residences
- community service workers
- telephone support callers
- community service organizations
- homemakers
- nursing aides

- home visitors
- volunteer coordinators

Families and friends of seniors:

- those who participate in making lifestyle decisions with seniors
- those who provide information, support or service to seniors

Health care or helping professionals:

- community health nurses
- home care nurses
- hospital staff nurses
- professional associations
- educational institutions
- physicians
- pharmacists
- psychologists
- clergy

Distribution:

Well Informed is scheduled for distribution in June 1991. Additional information will be available at that time through local AADAC offices.

The package is being produced with the sponsorship of Norcen Energy/Superior Propane.

V. ALBERTA ASSOCIATION ON GERONTOLOGY

AD HOC COMMITTEE ON SUBSTANCE ABUSE AND THE ELDERLY

The Alberta Association on Gerontology (AAG) has been actively involved in the area of substance abuse and the elderly since 1983. During this period, an Ad Hoc Committee of the AAG has been advocating research and education as central themes in responding to the growing concerns of practitioners relative to substance abuse. It is generally recognized that the larger and more general area of substance abuse including prescribed medications, over the counter medications (non-prescribed) and alcohol continue to present a challenge to researchers and practitioners.

Since the initial Outreach Conference sponsored by the AAG in 1983, the organization has continued to meet its commitment to its membership and other practitioners in developing, providing and sponsoring a variety of activities related to substance abuse and the elderly.

A training workshop was sponsored by the AAG at the Canadian Association on Gerontology (CAG) Conference held in Calgary in the fall of 1987.

With the assistance of the AAG Research Committee, an annotated bibliography on substance abuse and the elderly was compiled in 1988 with S.T.E.P. funding and updated again in 1990.

In September 1988, the Ad Hoc Committee applied for and received a grant from the Seniors Independence Program, Health and Welfare Canada. The intent was to conduct a research project in order to determine the attitudes to and the educative needs of practitioners throughout Alberta. The focus of the research project is alcohol use/abuse, but only in order to ensure economy of time, effort and funds.

The first phase of the project was an extensive, thorough study of the needs of the practitioners and was completed early in 1990.

The second phase is to develop training modules which would enable professionals/practitioners to function as trainers in their own work settings or

geographical area. The final phase of the project will be the evaluation, outcome and recommendations of the "Training the Trainers" programme, due for completion in the fall of 1991.

The Ad Hoc Committee on behalf of the AAG has responded in the role of advocacy, when appropriate, on issues dealing with substance abuse and the elderly.

Both the Seniors Advisory Council for Alberta and the AADAC have been jointly involved in numerous activities since the inception of the Ad Hoc Committee and have contributed generously both in financial and resource support.

The Ad Hoc Committee has been very cognizant of the need for networking and has sought and promoted interest, action and support from many agencies, organizations and individuals in the desire to address the expressed needs of practitioners.

The Ad Hoc Committee research/training project focuses specifically on alcohol use/abuse. Alcohol is a drug, and as a drug can seriously interact with other drugs, as well as seriously impact on the quality of life for an elderly individual.

The other sessions of the forum have made reference to the impact and importance of **ATTITUDE** and **KNOWLEDGE** in the awareness, detection, assessment and intervention in substance abuse. The results of the S.I.P.-funded research project also confirm this observation. Some of the interesting points are cited below:

1. Attitude of Practitioners to Elderly Alcohol Abusers

In general, attitudes ranged anywhere from unsympathetic to indifferent. The researchers concluded that practitioners were not forming attitudes on factual knowledge, rather that they were products of stereotyping. It is also suggested that these prevailing attitudes in the health care and service community are counterproductive to the task of caring for and treating the elderly with drinking problems.

2. Adequacy of Knowledge

Less than 4% of agencies, institutions and community settings represented have programs/policies concerning the care and treatment of the elderly problem drinker.

3. Incidence of Alcohol Abuse

Researchers admit that it is impossible to determine just how many older people abuse alcohol. Anywhere from two to ten percent (2-10%) of the population over age sixty abuse alcohol.

4. Analysis

The need for knowledgeable, skilled practitioners is strong. First, practitioners must evaluate their own attitudes to aging and alcohol use/abuse. Awareness of alcohol use/abuse, the causes of misuse and the effects of same are all equally important factors and require current and in-depth knowledge. Factual information on the outcomes of alcohol abuse, assessment and intervention skills plus the knowledge of community resources will enable them to be effective care providers.

5. The Training Modules

The training modules developed by Dr. Lynn McDonald and other consultants are geared to all levels of practitioners working with the elderly. The training program has established seven (7) primary objectives ranging from increasing practitioners' awareness of their own attitudes toward the elderly and alcohol use/misuse, increasing awareness of the causes of abuse to improving assessment and intervention skills.

The training modules are self-contained study units and will be available for sale and distribution when ownership/administration guidelines are established by the AAG.

Currently, copies of the annotated bibliography are available ($5/copy) and provide extensive sources of information useful for self study.

APPENDIX A

INFORMATION ON

THE SENIORS ADVISORY COUNCIL FOR ALBERTA
and
THE ALBERTA ASSOCIATION ON GERONTOLOGY (AAG)

The Seniors Advisory Council for Alberta

The Seniors advisory Council for Alberta is a government-appointed and funded body. Its members are appointed by the Associate Minister of Family and Social services on advice of Executive Council. The current chairman of the Council is Thomas Musgrove, MLA, representing the Bow Valley constituency.

The Council consists of 15 members in all, including the chairman. Two members are from the Calgary area, two from the Edmonton area, one each from Lethbridge, Medicine Hat and Red Deer areas, one from northern Alberta, and three from various rural areas. There are three additional members representing the Alberta Medical Association, the Alberta Hospital Association and the universities.

The Council makes recommendations to the government on policies and programs relating to older people and the coordination of policies and programs. It does this through the submission of an annual report and by responding as requested to government reports and specific requests for advice.

The Council provides a province-wide information service, responding to requests by telephone, letter and personal interview. It operates the toll free Seniors Information Line (1-800-642-3853). Through the publishing of booklets and papers such as Programs for Seniors and the bi-monthly Fact Sheet, it provides information on programs and on issues relating to seniors. The co-sponsoring of workshops and forums and the provision of grants relating to aging also assists in educating the public, including the senior public, about the needs an concerns of older people.

Since 1986, the Council has spearheaded the annual provincial Senior Citizens Week, the focus of which is to promote a greater understanding of aging and the contributions which seniors make to Alberta society.

The address of the Council is 405 Energy Square, 10109 106 Street, Edmonton, Alberta, T5J 3L7; telephone, 427-7876 and 1-800-642-3853

Alberta Association on Gerontology (AAG)

The Alberta Association on Gerontology (AAG) is a province-wide voluntary organization that seeks to enhance the lives of the aging population through support of persons involved in and concerned with gerontology. The Association is interdisciplinary with over 400 members, including senior citizens, seniors' organizations, senior centres, home care programs, health units, hospitals, long term care facilities, housing units and interested individuals.

Established in 1980, the Association has provided a vehicle for networking, information exchange, education, promotion of research and increased public awareness of issues related to gerontology. In order to facilitate communication, education, and information-sharing at a local level, chapters have been established in Edmonton, Calgary, Lethbridge and in the North West region. Additional chapters will be developed in other regions.

Regional workshops are held as well as an annual conference. The Association frequently collaborates with other organizations in planning these events.

A newsletter is currently published five times a year.

The Association has an Ad Hoc Committee on Substance Abuse which is currently working on a research project, "Training the Trainers."

The mailing address for the Association is c/o Centre for Gerontology, P220, Biological Sciences, University of Alberta, Edmonton, Alberta, T6G 2E9.

APPENDIX B

NAMES OF PANEL MEMBERS, DRAMA GROUPS

LEADERS OF THE ENERGIZE BREAKS

MEDICINE HAT FORUM

March 7, 1991

Panel Members

Moderator: Stan Wiens, AADAC

Larry Legare, pharmacist, Medicine Hat Regional Hospital
Evelyn Tate, Home Care Nurse, Southeastern Alberta Health Unit
Mary Kundert, representative, senior community

Drama Group

Medications Awareness Committee, a Subcommittee of the Medicine Hat Needs of the Elderly Planning Committee

Energize leader

Pam Wenzel

GRANDE PRAIRIE

March 14, 1991

Panel Members

Moderator: Mary Claire Binns, Grande Prairie chapter, AAG
Irene Krowchuk, pharmacist, Shamrock Drugs, Grande Prairie
Sharon Robert, Community Health Nurse, Spirit River
Ella Demaine, representative, senior community

Drama Group

Royal Oak Players, Grande Prairie

Energize leader

Charlene Kushner, Community Services, Grande Prairie

CALGARY

March 21, 1991

Panel Members

Moderator: Audrey Sissons, Calgary chapter, AAG

Dorothy Groves, consumer
Bob Reder, pharmacist, Mission Pharmacy, Calgary
Dr. Christine Grabenstetter, Alexandra Community Health Centre, Calgary

Drama Group

Good Companion Spotlighters, Calgary

Energize leader

Kirston Aston, Recreation Program Director, Renoir Manor, Calgary

EDMONTON

March 25, 1991

Panel Members

Moderator: Brenda Higham, AAG, Edmonton Chapter

Hazel Wilson, representative, senior community
Sharon Tell, Home Care Coordinator, Leduc-Strathcona Health Unit
Noreen Vanderburgh, pharmacist, Edmonton General Hospital
Dr. Kathy Lechelt, geriatrician, Edmonton General Hospital

Drama Group

Second Edition Players, Edmonton

Energize leader

Marion MacCallum, Alberta Recreation and Parks

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